Wellspring Health Access
Patient Registration Form

CONTACT INFORMATION: We need accurate contact information to notify you of any abnormal medical findings. You ***must*** give us some way to contact you. If your phone does not accept blocked numbers, we may not be able to guarantee confidentiality. If this may cause a problem, please discuss this with a staff member. Non-identifying information may be used for program evaluation and research. ***In case of an emergency or life-threatening medical condition, confidentiality may be broken.***

PLEASE PRINT

Legal First Name____________________M.I. ______________

Legal Last Name ______________________________________

Preferred name (if different) ___________________________

Date of Birth:______________________Age:______________

Gender:

Address:______________________________Apt. # _________

City________________________State________Zip __________

Preferred Phone # ___________________________

Alternate Phone #____________________________

Employer:____

Occupation:_______________________________________

Who is here with you today? ___________________________

Emergency Contact

Name____

Phone # ____________________________________

How did you hear about us?

☐ Internet ☐ Friend/Relative ☐ Yellow Pages

☐ Here Before ☐ NAF ☐ Other

☐ Doctor/Health care Provider ________________

Insurance

Do you have Healthcare Coverage? (Check one): ☐ Yes ☐ No

Please answer this question even if you plan to pay cash today. This helps us help you with contraception options and lab tests. Please give card to reception.

Insurance Name: ______________________________________

Are you insured by Medicare/ Medicaid? ☐ Yes ☐ No

Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Insurance Policy#:_____________________________________

Group #: ____

Effective/Print Date: ___________________________________

Subscriber's Name: ____________________________________

==

How would you like us to contact you?

Phone:____________________________________or

Email:____

==

What services do you need today?

____

I verify that I have answered these questions to the best of my ability. I am financially responsible for any balance due.

ULTRASOUND/FETAL HEART TONE CONSENT/CERTIFICATION

In accordance with the Wyoming Statutes, this form shall certify the following: I was offered the opportunity to view an active image of the ultrasound and to hear the fetal heart tones (if present) at the conclusion of the ultrasound preformed at Wellspring Health.

I have elected to:	Y	N
To view the sonogram	☐	☐
To listen to the fetal heartbeat (if present)	☐	☐
To receive a picture	☐	☐
To know if the pregnancy contains multiples	☐	☐

PATIENT NAME:________________________**SIGNATURE**__________________________________ **DATE:**______________**TIME**_________

Reviewed and discussed by staff:____ DATE:_________________________

Physician Name:_______________________Signature:_____________________________________ DATE:________TIME___________

Wellspring Health Access
918 E 2nd Street
Casper, WY 82601
307.224.8752

Health Information Portability and Accountability Act
(HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review the HIPAA privacy notice carefully.
Passage of HIPAA occurred to improve the efficiency and effectiveness of the health care system by standardizing the transmission of certain transactions and protecting the privacy and security of the patient's personal health information.
Privacy Rule essentially controls the use and disclosure of protected health information (PHI). The Security Rule protects and safeguards confidentiality of medical information and information that could identify an individual.
Wellspring Health Access understands that your medical information is private and confidential. All Physicians and staff must adhere to these policies.

As required by law, the HIPAA privacy notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. You can request a written copy of our most current privacy notice.
If you have any questions or would like furthering information about this notice, please contact Wellspring Health Access.

I,_________________________________, acknowledge that I have been offered a copy of Wellspring Health Access' Privacy Notice and I have read that information that is posted in the lobby.

____ ____________________
Signature of Patient Date

____ ____________________
Signature of Parent/Guardian (if minor) Date

Wellspring Health Access' **Privacy Policy**

I have read Wellspring Health Access' privacy policies and patient bill of rights and have been offered a copy.

____ ____________________
Signature of Patient/Guardian Date

Wellspring Health Access' **Advance Directive Policy**

I have read Wellspring Health Access' Advance Directive Policy and have been offered a copy.

____ ____________________
Signature of Patient/Guardian Date

Patient Consent for Text and Voice Appointment Reminders and Messaging

I authorize Wellspring Health Access to communicate with me via:

☐ Text and/or Voice at ____
☐ Email at _______________________________________

I ☐ Do **OR** ☐ Do NOT give my express consent to receive automated text and voice messaging to the number listed above.

Patient/Guardian Name ____
Patient/Guardian Signature ____

Wellspring Health Access
Health History

Please print your full name here:____Date of birth:____________________

Do you have any allergies to medications, metals, latex, rubber gloves, tape, shellfish, or antiseptic solutions (iodine/Hibiclens)?

No ☐ Yes ☐ *If yes, list allergy and reaction*____

Have you ever had a bad reaction to anesthesia or sedation? ☐ NO ☐ YES *explain*:__________________________________

Current medications:____

SOCIAL HISTORY

No	Yes	
☐	☐	Do you smoke or chew tobacco? If yes, how many/much a day? _______________
☐	☐	Do you drink alcohol? If yes, how often and how much?____
☐	☐	Have you ever used street or IV drugs?____

CONTRACEPTIVE HISTORY

Are you interested in getting birth control today? ☐ no ☐ yes If yes, what: ____

What birth control method are you currently using?____

What methods have you used in the past?____

Any problems with your previous methods? ☐ no ☐ yes If yes, explain:____

PREGNANCY HISTORY (Please include current pregnancy)

When was the first day of your last menstrual period?___________________Are you breastfeeding now? ☐ no ☐ yes

Number of: Pregnancies_____Vaginal deliveries_____ C-sections_____ Miscarriages_____ Abortions_____ Ectopic(tubal) _____

When did your last pregnancy end?___________________Any complications? ____

PAST MEDICAL HISTORY Have you **EVER** had any of the following:

No	Yes		No	Yes	
☐	☐	Heart disease or serious heart valve problem	☐	☐	Uterine abnormalities/fibroids
☐	☐	Pulmonary Embolism (PE), heart attack, or stroke	☐	☐	Seizure or epilepsy
☐	☐	Bleeding problems or anemia	☐	☐	Asthma, breathing problems, other lung disease
☐	☐	Serious medical problems, hospitalizations, surgeries: ____	☐	☐	Migraine

REVIEW OF SYSTEMS: Do you ***NOW*** have any of the following:

No	Yes		No	Yes	
☐	☐	**Cardiovascular**: Severe chest pain	☐	☐	**Respiratory:** Difficulty breathing
☐	☐	**Neurological:** Migraine OR severe headache	☐	☐	**Genitourinary:** Severe/persistent pelvic pain
☐	☐	**Endocrine:** Excessive thirst or night sweats	☐	☐	**Genitourinary:** Abnormal discharge or itching
☐	☐	**Lymph:** Painful or swollen glands in your groin	☐	☐	**Genitourinary:** Severe pain with periods
☐	☐	**Gastrointestinal:** nausea or severe abdominal pain	☐	☐	**Mouth:** Bumps or sores in the mouth
☐	☐	**Chest/Breast:** lump, constant pain, or nipple discharge			

Patient signature:____ Date:______________________

Wellspring Health Access

Authorization for Release of Information to Family Members/Friends

Patient Name: ________________________________ Date of Birth: ______________________________

(PRINT)

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to friends/family members, you must sign this form. Only individuals listed on this form will be authorized to obtain/inquire about medical and billing information for the patient.

I authorize Wellspring Health Access to release and discuss my medical and/or billing information to the following

individual(s):

1.______________________________________Relation to Patient:_____________________________

2. ______________________________________Relation to Patient:_____________________________

3. ______________________________________Relation to Patient:_____________________________

_______I do not authorize any individuals to inquire/request medical information regarding my treatment at Wellspring Health Access.

PATIENT INFORMATION

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

I have the right to revoke this consent in writing at any time.

SIGNATURE:____DATE:____________________

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS
AND CANCELLATION OF FUTURE APPOINTMENTS

Patient's Name:______________________________ Date of Birth: ___________________

Address:____________________________________ Home Phone: ___________________

City, State and Zip:___________________________ Other Phone: ___________________

Email: _____________________________________

REQUESTING RECORDS FROM: ___________________________________

____

____

____

MAIL OR FAX RECORDS TO: Wellspring Health Access
918 E 2nd St.
Casper, WY 82601
Phone: 307.224.7852
Fax: 307.224.7851

Please release medical records pertaining to the following:

____

Reason for requesting records:

____

****

I authorize the release of the above requested records, including those, which may contain confidential HIV/AIDS related information, confidential communicable disease related information, confidential information related to mental health, drug and/or alcohol use, or sexual history, and that the records be forwarded to the above name and address. I further authorize that these medical records may be faxed if necessary. I understand that I may revoke this authorization at any time, except to the extent that action based upon this authorization has already been taken. I have given my consent freely, voluntarily, and without coercion.

_______________________________ _____________________ ____________

Patient Signature Relationship to Patient Date
(or parent/legal guardian if minor)

Wellspring Health

Access

Consultation

Worksheet

Name:____

What options did you consider before makingyour decision? ☐ Abortion ☐ Adoption ☐ Parenting

Does the other person involved know about the pregnancy?

Are they supportive of your decision? ☐ Yes ☐ No ☐ Does not know.

On a scale of 1-10 (with 1 being very easy and 10 being very difficult), how hard was it for you to make this decision?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Who have you talked to about your pregnancy? ☐ Partner ☐ Parents ☐ Friends ☐ Other Family ☐ Spiritual/ Religious ☐ Other ____

Are you confident about your decision to terminate this pregnancy? __________

Would you like more information about: ☐ Adoption ☐ Parenting ☐ Community Resources ☐ Pre-natal Care and/or Insurance ☐ Abortion Options (medication surgical) ☐ other ____________

If you drink alcohol or use drugs, please answer the following four questions:

Have you felt that you ought to cut down on your drinking or drug use? ___
Have people annoyed you by criticizing your drinking or drug use? ____
Have you felt bad or guilty about your drinking or drug use? ____
Have you ever had a drink or used drugs first thing in the morning to steady your nerves, to get rid of a hangover, or to get the day started? ____

If you are under 18, you MUST answer the following two questions:
Are you comfortable with the sexual experiences you have had? _____
Has your partner ever made you feel uncomfortable or pressured you in sexual matters? _____

Do you have any concerns today that you would like to discuss with the doctor or patient care coordinator?

____
____

This portion of the form will be filled out during the consultation session.

The following has been discussed with the patient:

- ☐ Patient has considered all their options: abortion, adoption, and parenting.
- ☐ Patient has made theirown decision and expressed confidence in that decision.
- ☐ Patient’s questions about the procedure and aftercare were discussed.
- ☐ Reviewed contraceptives and importance of keeping the follow-up appointment.

Patient signature:____Date:___________

Patient Care Coordinator signature:______________________________________Time:_________AM/PM

Wellspring Health Access
Vital Statistics Reporting

The following information is required by Wyoming State law and is both confidential and anonymous.

Name_______________________________
Age _______________________

Number of years of education (check one) ☐ 8th Grade or Less ☐ 9th-12th Grade (No Diploma) ☐ High School Graduate/GEDCompleted ☐ Some College Credit (No Degree) ☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate or Professional Degree

Residence State___________County______________City______________________Do you live in thecity limits? ☐ Yes ☐ No

Are you Hispanic? ☐ Yes ☐ No **If yes, please specify:** _______________________

Race:
☐ White ☐ Hispanic ☐ African American ☐ American Indian ☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Other:________________

Married:
☐ Yes ☐ No

Total number of pregnancies **NOT** including this one ____________________

Number of live births _____________________

Number of abortions _____________________

Number of prior miscarriages ______________

Patients do not write below this line

Physician______________________

Patient # _______________________

Date _______________________

Gestational age ________________

Last Menstrual Period________________

Reason (check one) ☐ elective ☐ medical - mother / medical - fetus: ☐ anencephaly ☐ spina bifida ☐ other__________
Procedure (check one) ☐ Surgical ☐ Medical ☐ D&E

Medical complication____

Medical conditions ____

Medical emergency ____

Report number: _______________________

Wellspring Health Access

PREOPERATIVE INFORMATION CONSENT FORM FOR PROCEDURAL ABORTION

<u>Please initial each line below</u>:

_____I hereby request and consent to have Dr.______________________perform a procedural abortion. I fully understand the purpose of this procedure is to terminate my pregnancy. This is my personal decision, and no one has coerced me or compelled me to make this decision. After full consideration of all my options including continuing the pregnancy and adoption, I have chosen not to continue the pregnancy.

_____I have completely and accurately disclosed my medical history including any health conditions, sexually transmitted infections, known allergies and medications or drugs taken within the last forty-eight hours. I authorize the physician to make medical decisions based upon these disclosures.

_____I consent to the taking and testing of blood samples. I understand these tests are routinely performed and are a necessary component of my care to check my blood type and. I understand that the products of conception will be removed during the abortion, and I consent to their disposal by the physician and Wellspring Health Access in a manner deemed appropriate.

_____I consent to the administration of an oral or IV narcotic or anxiety reducing medication, if I have a ride, which is intended to control pain and relax me during the procedure. If I receive this, I may experience drowsiness, fatigue, poor muscular coordination and partial amnesia. I understand that in a small number of women severe reactions or shock may occur requiring emergency care.

_____I understand that all forms of anesthesia involve risks and no guarantees can be offered to me regarding my treatment or its outcome. Possible risks include decreased awareness, aspiration and depressed respiration. If I receive an oral or intravenous narcotic or anxiety reducing medication, I understand that I must not engage in activities that require mental alertness, including driving a motor vehicle, operating machinery or making any financial or business decision for twenty-four hours.

Driver-Choose One:

_____I understand that if I take the oral or intravenous narcotic or anxiety reducing medication during my visit to Wellspring Health Access, I must not drive myself home after my procedure nor engage in any activity requiring mental alertness for twenty-four hours. I have brought a driver with me and they will be responsible for ensuring my safe return home.

Driver's Name (Printed):_____________________________________Driver's Contact Tel#__________________

Drivers Signature: ____

OR

_____I have failed to bring a driver to provide me a ride home. Therefore, I am arranging for a taxi to drive me home. I have been given the option to reschedule my appointment but am choosing to proceed. I understand that the physician will use her judgment to determine which medications I can receive. I hereby release the physician and Wellspring Health Access of any and all liability and responsibility for my safe return home after receiving any medications.

_____I am refusing the oral or intravenous narcotic or anxiety reducing medication during my visit. I have been given the option to reschedule my appointment but am choosing to proceed. I understand that the physician will use her judgment to determine which medications I can receive. I hereby release the physician and Wellspring Health Access of any and all liability and responsibility for my safe return home after my procedure.

Procedure:

_____I understand that an abortion consists of opening the cervix (the entrance of the uterus) with surgical instruments and/or other dilators and using suction and/or surgical forceps to remove the contents of the uterus. This is one of the most common and safest surgical procedures done in the United States. The actual procedure takes 5-10 minutes.

_____An ultrasound will be done to determine how far along my pregnancy is. The ultrasound may possibly be done by putting the ultrasound probe in my vagina. The only purpose for this ultrasound is for gestational dating, to ensure an intrauterine pregnancy and to identify the placental location if needed. It is not for other diagnostic purposes.

_____I understand the procedure and I will make sure all of my questions are answered completely to my satisfaction.

_____I understand that complications with surgical abortion are uncommon but could include the following:

* 1 per 100: Laceration (tearing) of the cervix which may require medication or suturing.

* 1 per 1000: Perforation or injury to the uterus which may include damage to internal organs. Hospitalization could be required and surgery may be necessary.
* 1 per 1000: Hemorrhage, heavy bleeding that may require evaluation of the patient and further treatment. A blood transfusion might also be needed very rarely.
* Reaction to the anesthesia and/or medications resulting in shock, convulsions or death.

_____I acknowledge that the complications that may occur after the procedure are the following:

* 1 per 100: Post Abortion Syndrome, trapped blood clots in the uterus that may cause severe cramping and abdominal pain. A second procedure may be required.
* Less than 1 per 500: Continuing pregnancy that may be due to multiple pregnancies, double uteri or ectopic pregnancy. A second procedure would be required, and an ectopic pregnancy may require hospitalization and treatment.
* 1 per 1000: Infection of the uterus with or without infection of the fallopian tubes and ovaries, which may require antibiotic therapy and very rarely can lead to the loss of childbearing capacity.
* Hemorrhage, heavy bleeding that may require evaluation of the patient and further treatment.
* Emotional problems. Although most women report relief, some women may experience depression or guilt following an abortion. Our staff is available to help women deal with these feelings or provide appropriate referral.
* 1 per 160,000: Death. In comparison, a woman's risk of death during pregnancy and childbirth is ten times greater.

_____In the event of an emergency, I authorize the physician to provide emergency care using her medical judgment, including transfer to a local hospital. I understand that patient confidentiality cannot be preserved if transfer to a hospital is necessary. In the event of an emergency, I authorize the physician and staff to contact the following individual:

Name____Relationship_________________________________

Street Address:____City/State_____________________________

Telephone number___________________________________Alternate number____________________________

_____I understand that I would be financially responsible for any expenses arising from complications from the abortion procedure. I understand that such complications can be caused by my own condition or conduct and through no fault of the physician. I understand that no guarantees about my future fertility can be offered to me and no such guarantees have been made to me. I will receive written discharge instructions and I understand the importance of follow-up care. I agree to call Wellspring Health Access regarding any question or complications I may have. I understand Wellspring Health Access has the right to refuse me services for whatever reason they deem appropriate.

Second Trimester Dilation Consent

_____If determined by my doctor, I may receive Misoprostol or other medications that soften and dilate the cervix. I will then wait at the office for a minimum of 2 hours before the procedure is done. The visit will be approximately

4-8 hours.

____Depending on gestational age, the doctor will place several thin, sterile dilating sticks into my cervix. These will swell gradually and dilate my cervix. I will then wait for at least 6 hours, or overnight, before the procedure is done. The visit will be approximately 8 hours if done the same day, or two visits of approximately 4-6 hours each.

______________________________	______________________________	______________________________
Medical Provider's Signature	**Patient Signature**	**Date**

_________________________________**Parent or Guardian Signature (if patient is a minor)**

Wellspring Health Access

Authorization to Bill Insurance

I decline to have my insurance billed for the services received today. If you agree to have your insurance billed, skip to Section 1, and complete the rest of the form.

Patients Printed Name:______________________________Date of appointment: _____________________
Patients Signature: _________________________________

If you agree to have your insurance billed for the services received, please continue to fill out the information below.

SECTION 1: Patient Information

Last Name: ________________First Name__________________________Middle Initial: _____

DOB: __________ SS#: ________________ Daytime Phone: __________________________

SECTION 2: Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name: _____________________First Name: _______________Middle Initial: _________

Address: ____________________City: _______________State: _______ Zip: ___________

Phone: _________________________

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

____ ____________________________

Guarantor's Signature **Date**

I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that some third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Wellspring Health Access to release all medical information necessary to secure payment of benefits from the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing.

X _____________________________________ _______________________

Patient's Signature Date

X_______________________________________ _______________________

Guardian/Representative's Signature Date

____

Relationship to Patient/Representative Authority